State of California
REIMBURSEMENT CLAIM
TD-290 (Rev. 06/02)

California 9-1-1 Emergency Communications Office

Mail form to: Telecommunications Division, 601 Sequoia Pacific Blvd. MS-911, Sacramento, CA 95814-0282

Public Agency:	**Accounts Payable Name and Address**
Address:	
City, State, Zip:	
PSAP Manager:	
E-mail Address:	
Phone Number:	
Fax Number:	

Type of Reimbursement Claim:

- ○ 7-Digit Phone Lines
- ○ CALNENA
- ○ 9-1-1 Education
- ○ Maintenance
- ○ County Coordinator Expense
- ○ Other:

Description of equipment and services being submitted for reimbursement:

For each item listed below, PSAP shall attach detailed invoices, descriptions and quantities of services performed which validate reimbursement quantities and amounts. When applicable, PSAP shall note the Commitment To Fund 9-1-1 Equipment and Services (TD-288) form tracking number.

Description	TD-288#	Time Period of Claim	Total Cost Per Item	Amount Approved (9-1-1 Use only)
REIMBURSEMENT CLAIM TOTAL			$0.00	

I declare under penalty of perjury that the amount requested for each reimbursement is correct and is a legitimate claim for reimbursement from State 9-1-1 Program funds.

OFFICIAL AUTHORIZED TO SIGN FOR RESPONSIBLE PUBLIC AGENCY	**Name:**	**Title:**
	Signature:	**Date:**
	Address:	

State 9-1-1 Program Use Only

RECOMMENDED FOR APPROVAL BY	Telephone Number	Amount	APPROVED BY	Date